INDIVIDUALIZED HEALTH PLAN

The following child is enrolled in ___________________ (Head Start) program and has been identified as having special medical condition(s), and or nutritional concerns, and or disabilities and or rely on daily medication(s). Optimal health care for children with chronic conditions requires close communication and coordination among families, Head Start, and health care providers.

A systematic process of developing and following the Individualized Health Plan helps clarify the roles and responsibilities of all caregivers and facilitates collaboration.

In order to support and plan for the safest environment, information and a specialized plan from a licensed physician or health care professional is needed.

Part 1: Parent or Guardian to complete.

Date of Birth:______________ Male or Female	Child's Name:__________________________
Parent or Guardian Name:___________________________	Center Name:__________________________ Teacher Name:_________________________ Classroom #
Home Phone: ______________________ Cell Phone: ________________________ Work Phone: _______________________	Address:_________________________________ ____ ____

In accordance with the provisions of the Health Insurance Portability and Accountability Act of 1996 and the Family Education Rights and Privacy Act, I hereby authorize ___________________(Provider) to release such protected health information of my child as necessary for the specific purpose of completing the Health Care Plan. I consent to allow the physician/medical authority to freely exchange the information listed on this form and in their records concerning my child, ________________ (Head Start) as necessary. I understand that permission to release this information will expire on __/_____/_____(1 year from date signed).

This permission to release may be cancelled at anytime. This information is to be released for the specific purpose of health care planning. The undersigned certifies that he/she is the parent or guardian or representative of the person listed on this document and has the legal authority to sign on behalf of that person.

Signature of Parent or Guardian: ______________________________________Date:_____________

Part 2: To be completed by the Health Care Professional

**Note- This child attends our childcare facility during the week for at least 3.5 hours up to 7.5 hours per day. Please complete the information below with specific instructions for staff to follow while the child is in our care.*

Does the child have a special health care need that would require an Individual Health Plan while in school?

(Please mark the appropriate box) Yes ☐ No ☐ If yes please complete the sections below.

Describe the diagnosis, medical condition, developmental issues, allergies, intolerances and special needs:

____
____
____
____
____
____

List any restrictions or special diet.

____
____
____

Does the child require emergency medication on facilities site? Yes: ☐ No: ☐

Does the child require medication to be administered at home ONLY? Yes: ☐ No: ☐

Does the child require an emergency action plan? Yes: ☐ No: ☐

MEDICATION AUTHORIZATION FORM

Medication administered during school hours by Head Start Staff requires written orders from a licensed medical provider. All medications must be brought to school in the original properly labeled pharmacy container.

Child's Name_______________________________ Birth Date_______________________________
Parent/Guardian's Name______________________ Home # _______________________________
Home Address_______________________________ Alternate# ______________________________
Center Name________________________________ Classroom/Teachers_______________________

Name of Medication (s)	Dosage	Method/Route	Specific Time(s) to be given. "as needed/ prn" is not accepted.	Possible Side Effects

Duration of Medication Administration: From _______________ To ______________
(Limited to current school year)

Physician's Name (print/type) ______________ **Physician's Signature** ______________ **Date** ______________ **Physician's Phone #** ______________

Address ______________ **City** **State** **Zip Code** ______________ **Physician's Fax #** ______________

I give permission for school personnel to share this information, follow this plan, administer medication and care for my child and, if necessary, contact our physician. I assume full responsibility for providing the school with prescribed medication and equipment devices. I approve this Individualized Healthcare Plan for my child.

______________________________ ______________
Parent/ Guardian's Signature **Date**

Center Mgr. Signature ________ **Date** ________ **Asst. Health/Nutrition Mgr. Signature** ________ **Date** ________

Teacher Signature ________ **Date** ________

Building Assoc. Signature ________ **Date** ________ **Teacher Signature** ________ **Date** ________

EMERGENCY CARE PLAN

Emergency Action Steps:	Call 911 If:	Call Parent If:	While Waiting for Help: